dentalessence Worthing

CONFIDENTIAL MEDICAL HISTORY

Certain medical conditions can affect your dental treatment, so please provide as much information as possible in the questionnaire below.

SURNAME Mr/Mrs/Miss ____ SEX: MALE/FEMALE

FORENAME (S) ____

ADDRESS ____

____ POSTCODE __________________

TEL NO HOME: _____________________MOBILE ___________________WORK ___________________

EMAIL ADDRESS: ____

DATE OF BIRTH __________________________OCCUPATION __________________________________

WHEN DID YOU LAST RECEIVE DENTAL TREATMENT ____

YOUR DOCTOR'S NAME & ADDRESS ____

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How did you hear of dentalessence Worthing?____

	YES	NO	IF YES, PLEASE GIVE DETAILS
Are you able to manage the stairs?			
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods, or materials?			
Do you carry a warning card?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the Blood Transfusion Service?			
Have you ever had a bad reaction to a local or general anaesthetic?			
Do you have a pacemaker or have you had heart surgery?			

Please continue on next page…

	YES	NO	IF YES, PLEASE GIVE DETAILS
Do you suffer from hay fever, eczema or have any other allergy?			
Do you suffer from bronchitis, asthma or other chest condition?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in your family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?			
Do you think there are any other aspects, concerning your health, that your dentist should know about?			
On average, how much of the following do you consume per day?	Cigarettes ___________ Alcoholic Drinks ____________		

If you could change your smile what would you like to have done?	
How would you rate your smile from 1-10? 1 – I'm embarrassed / 5 – it's average / 10 – it's beautiful	**1 2 3 4 5 6 7 8 9 10**
If applicable, would you like to change your old black fillings?	Yes ☐ No ☐
Would you like to have straighter teeth?	Yes ☐ No ☐
Would you like to have whiter teeth?	Yes ☐ No ☐
Are you concerned about any gaps/missing teeth/black lines around teeth or existing crowns?	Yes ☐ No ☐
Please circle any of the treatments below which you may like your dentist to discuss with you in more detail. **Implants Veneers Braces (Cosmetic or Fastbraces) Veneers Smile Makeover Botox**	

Please circle **THREE** words / phrases to highlight which aspects of your dental care are most important to you:

Cleanliness Convenience of appointments Service Friendly Staff Communication skills of your dentist

Dental Charges Latest equipment Pain free dentistry Sympathy towards my nervousness

SIGNED ____ DATE _____________

Patient / Parent / Guardian (delete as applicable)